SCDC POLICY/PROCEDURE

Change 3 to HS-19.02:1.5

Change 2 to HS-19.02:8.7

Change 1 to HS-19.02: 17.6.3

NUMBER: HS-19.02

TITLE: MENTAL HEALTH SERVICES

ISSUE DATE: July 1, 2008

RESPONSIBLE AUTHORITY: DIVISION OF MENTAL HEALTH SERVICES

OPERATIONS MANUAL:HEALTH SERVICES

SUPERSEDES: HS-19.02 (October 1, 2000)

RELEVANT SCDC FORMS/SUPPLIES: 19-11, 19-29, 19-45, 21-6, M-53, M-122, M-123, M-131, M-132, M-140

ACA/CAC STANDARDS: 4-ACRS-5A-08, 4-ACRS-6A-11, 4-ACRS-7D-07, 4-4095, 4-4098, 4-4099, 4-4256, 4-4277,4-4285, 4-4286, 4-4305, 3-4330, 3-4336, 3-4344-1, 3-4350, 3-4355, 3-4367, 3-4369, 3-4377, 4-4428, 4-4429, 4-4430, 4-4431, 4-4433, 4-4434, 4-4435, 4-4436, 4-4438, 4-4439, 4-4440,4-4441, 4-4442, 4-4446

STATE/FEDERAL STATUTES: NONE

PURPOSE: To establish guidelines for inmates to access mental health services.

POLICY STATEMENT: The Agency is committed to providing inmates access to mental health services, as necessary . All newly admitted inmates will be screened for mental health needs, intellectual capacity, chemical dependency, and academic achievement. Inmates demonstrating the need for mental health services will be provided such in accordance with all applicable Agency policies/procedures, and state and federal statutes.

TABLE OF CONTENTS



SPECIFIC PROCEDURES:

1. GENERAL PROVISIONS:

1.1 This policy/procedure is meant to refer broadly to the system of the delivery of services by the Division of Mental Health Services and its employees. It refers primarily to services to mentally ill and other special needs inmates. However, it is expressly understood that Mental Health Professionals (MHP) referred to in this policy will evaluate ANY inmate, including those classified as "No Mental Health Treatment" (NMH) or as "Substance Abuse" (SA). The usual procedure for doing so is delineated in Paragraph 16, "Referral to Mental Health Services" section of this policy. All reasonable requests for evaluation are honored. Referrals for consultation may come from physicians, nurses, family members, chaplains, other inmates, Wardens, security personnel, or other SCDC employees. The Clinical Correctional Counselor (CCC) will facilitate the process of changing an inmates classification to "Mentally Ill," if this is appropriate. In any event, the CCC will work with the inmate and concerned staff to the best of his/her professional ability until the identified issue is resolved.

1.2 Mental health services will include, but not be limited to: assessment, case management, treatment, and discharge planning. (3-4330)

1.3 Mental health services will be provided to inmates classified as mentally ill.

1.4 The primary services of the mental health staff will occur in the following settings:

•Gilliam Psychiatric Hospital or a contracted facility;
•Intermediate Care Services;
•Area mental health centers;
•Outpatient services that are provided in most SCDC institutions; and
•Other special needs programs.

1.5 Beyond the traditional mental health services provided, the Behavior Health~~mental health~~ staff will interface with various special needs groups to provide mental health services as required. Since many special needs inmates also have a mental health and/or medical diagnosis, their programs will be located at facilities which provide for necessary medical, psychiatric, and mental health coverage and allow for the management of any psychotropic medication. ~~Mental health~~Behavior Health and medical personnel will coordinate with program staff to ensure that the inmate is receiving concurrent services to the special needs population. The following special needs groups are currently provided this service:

•Habilitation Unit (Hab Unit);
•Sexual Offender Treatment Program (SOTP);
•Youthful Offender Intensification Program (YOIP);
•Substance Abuse Treatment;
•Women's Services;
•Handicap Unit; and
•Hospice~~; and~~.
~~•HIV positive inmates.~~(4-4305)

1.6 Clinical Correctional Counselors will be encouraged to contact community social service resources to assist them in augmenting social services provided in the institution. (4-4431)

1.7 All inmates identified as mentally ill (Medical Classification MI-1, MI-2, MI-3, or MI-4) must be monitored by mental health staff regardless of whether or not psychotropic medication is prescribed, or whether or not the inmate is compliant with his/her prescription medication.

1.7.1 Inmates designated as MI 1: male inmates are generally found in Gilliam Psychiatric Hospital; female inmates are placed in a contract facility. The Clinical Correctional Counselor generally sees them at least monthly.

1.7.2 Inmates designated as MI 2: are generally found in Intermediate Care Services (ICS) or Area Mental Health Institution. They are generally seen by the Clinical Counselor on at least a monthly basis and require treatment updates quarterly.

1.7.3 Inmates designated as MI 3: are generally found in Outpatient Mental Health Services. They are generally seen by the Clinical Counselor at least every ninety (90) days and require treatment update every six months.

1.7.4 Inmates designated as MI 4: are generally found in Outpatient Mental Health Services at level one institutions. They are generally seen by the Clinical Counselor at least every six months and require treatment updates yearly. These inmates should be discharged from Mental Health Services when stable.

1.8 Inmates are considered admitted to Mental Health Services after the Health Summary has been revised to indicate MI status. They will subsequently be assigned to institutions that provide the appropriate level of mental health care.

1.9 Inmates on psychotropic medications will be housed at institutions where medical and mental health personnel can appropriately administer and monitor those medications.

2. RECEPTION &EVALUATION:

2.1 All inmates will be given a mental health screening at R&E. They will be screened for mental health needs, intellectual capacity, chemical dependency, and academic achievement. (4-ACRS-5A-08, 4-ACRS-6A-11, 4-ACRS-7D-07, 4-4285, 4-4286, 4-4305, 3-4344-1)

2.2 Phase I (All inmates): Three basic screens are administered using a group format, as follows:

•chemical dependency;
•intelligence; and
•school achievement test (measures grade equivalency in math and reading skills).
2.3 A member of the classification staff will administer a series of questions regarding mental health needs to assess depression and suicide risk during an intake interview. That classification staff member will initiate a referral for a Phase II evaluation.

2.4 Results of the screening will be processed as follows:

2.4.1 If no further evaluation is necessary, the inmate's name will be submitted to medical on a "No Referrals Generated" list. The physician may then complete SCDC Supply M-123, "Health Summary for Classification/Assignment."
2.4.2 Inmates whose testing indicates potential mental health problems and/or concerns will be referred to a mental health professional for a Phase II evaluation.

2.4.3 As part of the general medical examination and screening, any physician, nurse, or nurse practitioner evaluating inmates in R&E may also refer any inmate to a mental health provider for an evaluation if one has not already been recommended by the above process.
2.5 Phase II: A Phase II evaluation will be conducted as a general assessment by a Mental Health Professional (MHP) based on Phase I indicators. The interview will attempt to clarify any concerns or needs regarding substance abuse, mental health, mental retardation, sex offenses, and medical needs. When possible, Phase II will be completed prior to the initial medical exam by the physician. If not possible, the

nurse will place a note on the front of the chart indicating that a Phase II evaluation is needed. If the MHP is able to gather sufficient information to provide the physician assistance in determining treatment and placement needs, the respective inmate's mental health and special needs portion of the evaluation will be completed. The computer generated R&E Assessment Referral Form will be completed and forwarded to medical staff so that the physician can complete SCDC Supply M-123, "Health Summary for Classification/Assignment."

2.6 If, after the Phase II evaluation, the interviewer is unable to obtain a sufficient diagnostic impression, s/he will indicate the need for special assessment by a Phase III clinician and will forward the completed R&E Assessment Referral Form to the MHP who coordinates Phase III evaluations, and a copy will be sent to the medical staff.

2.7 Phase III: This evaluation by a MHP may consist of a clinical interview, battery of tests and/or a full psychological evaluation, and/or a clinical examination and treatment (if necessary) by a psychologist or psychiatrist. The result of this evaluation will be documented in the Automated Medical Record (AMR) as a clinical note and forwarded to the physician to assist in determining placement and treatment recommendations. If an inmate is determined to be mentally ill the psychiatrist must make the placement and treatment recommendation. This note will be documented in the Description Assessment Plan (DAP) or the Subjective/Objective Assessment Plan (SOAP) format in the CRT and will document the diagnosis and program recommendation.

2.8 Guilty but Mentally Ill (GBMI): Male inmates arriving at an R&E Center with a GBMI conviction will automatically be sent to Gilliam Psychiatric Hospital (GPH) for evaluation. Female inmates will be evaluated within three (3) hours of their arrival at SCDC. Based on the results of the evaluation, an appropriate treatment plan will be developed. If hospital care is needed they will be sent to a contract facility.

2.9 Admissions to Psychiatric Hospital During the R&E Process:

2.9.1 Males: When inmates are admitted to GPH while undergoing the classification process at R&E, the inpatient evaluation will serve as the primary source of information for institutional assignment and treatment recommendations. (NOTE: The inmate will still need a complete R&E physical and other R&E processing.)

2.9.2 Females: The R&E mental health evaluation process will stop upon the admission of a female inmate to a contract facility. Upon the inmates return to the SCDC, the mental health evaluation will resume and any information obtained from the contract facility will be incorporated. (NOTE: The inmate will still need a complete R&E physical and other R&E processing .)(3-4367)

3. ASSIGNMENT TO INPATIENT MENTAL HEALTH SERVICES:

3.1 Inpatient mental health services will be provided to inmates with extreme acute mental health problems. Inmates with the following characteristics who are medically stable, as determined by a SCDC medical physician will be appropriate for inpatient hospitalization:

•inmates who demonstrate that they are dangerous to self or others and/or who are unable to care for their needs due to a mental illness;
•inmates who are grossly impaired in their ability to function or communicate, or who are impaired in their capacity for reality testing due to a mental illness;

Admission (voluntary or involuntary) will be managed based on the procedures outlined in SCDC Policy/Procedure HS-18.13, "Health Screens and Exams." (Male inmates will be assigned to GPH. Female inmates will be assigned to a contract facility.)

3.2 Emergency Situations: An inmate arriving with or developing a condition that warrants immediate assessment due to being a danger to him/herself or others will be referred to medical staff for immediate evaluation and/or action. The inmate will not be left alone while awaiting medical assessment. Security Staff/Operations must be notified by Medical Staff to obtain their immediate assistance. If the situation arises after hours, the medical staff at the covering institution will be contacted and the referring institution will transport the inmate to the designated medical facility for "face-to-face" assessment with medical staff at the appropriate 24 hour institution. (3-4350)

3.3 Medical staff will complete an assessment of the reported condition, document the problem in the AMR/medical record, and implement the appropriate intervention. The following will apply:

3.3.1 If inpatient psychiatric hospitalization is indicated, voluntary or involuntary admission procedures will be followed (see SCDC Policy/Procedure HS-18.13, "Health Screening and Examinations," for admission procedures) and initiated by the medical staff member and physician.

3.3.2 If inpatient psychiatric hospitalization is indicated after an inmate has returned from Emergency Medical Treatments at a community hospital, the inmate must be seen and determined medically stable by a SCDC physician.

3.3.3 Any inmate who has ingested a foreign substance, is otherwise injured, or who has any general medical condition, will not be admitted to GPH or a contract facility until they have been personally examined by a physician who documents in the medical record that the inmate is "physically stable and medically cleared for admission to a psychiatric hospital." All involuntary admissions require a personal examination by a licensed physician.

3.3.4 If hospitalization is indicated but no bed is available, crisis intervention will be implemented. (See SCDC Policy/Procedure HS-19.01, "Procedures for the Placement of Inmates in Crisis Intervention Status," for more information.)

3.3.5 If hospitalization is not indicated, medical staff will determine the level of care needed. Inmates may be placed on Crisis Intervention Status (CIS) if the situation is warranted (see SCDC Policy/Procedure HS-19.01, "Procedures for the Placement of Inmates in Crisis Intervention Status," for more information) or referred to other appropriate available services.

3.3.6 Discharges from GPH and /or a contract facility: After an inmate has become stable, s/he will be discharged to the appropriate institution. For inmates who are released from incarceration in SCDC, refer to Paragraph 17, "Discharges for Inmates Receiving Mental Health Treatment."

4. INTERMEDIATE CARE SERVICES (ICS): Intermediate Care Services will be provided for inmates with a serious and persistent mental illness that requires intensive treatment, monitoring, and care.
4.1 Referral to ICS:

4.1.1 Inmates being considered for referral to any ICS will be assessed by the institutional or R&E MHP prior to a referral being made. The MHPs assessment will be provided to the treatment team. The treatment team, the MHP, or the attending physician can authorize a referral. The ICS Admission Screening form will be completed and then forwarded to the designated MHP for approval.
4.1.2 If approved, the Health Summary must be updated by a psychiatrist or psychiatric nurse practitioner to reflect MI-2, ICS assignment, along with the most recent diagnosis.

4.1.3 The designated MHP will then notify the Division of Classification and Inmate Records of the approval for a transfer. (3-4369)

4.2 Inmates with the following characteristics may be appropriate for ICS services:
4.2.1 Inmates whose GAF (Global Assessment of Functioning) Scale scores remain in the 31-50 range for extended periods or frequently become symptomatic enough to be reflected in this range;

4.2.2 Inmates whose GAF scale scores indicate:

•serious symptoms (mood, instability, suicidal ideation, severe panic attacks),
•serious impairment in ability to function, and
•impairment in reality testing, communication, judgment, and thought process;
4.2.3 Inmates who are poorly controlled on, or non-compliant with, medication;

4.2.4 Inmates who have failed to stabilize at other less intensive levels of care or who have a history of poor community adjustment, usually reflected in multiple hospitalizations;

4.2.5 Inmates who require highly structured environments or who are likely to be repeatedly hospitalized in other settings.

4.3 ICS must be located at an institution with:

•access to 24 hour nursing coverage;
•access to a psychiatry clinic;
•Monday through Sunday mental health staffing; and
•mental health providers readily on call at all other times.

4.4 Discharges from ICS: Refer to Paragraph 16., "Discharge/Community Release Planning" for inmates receiving mental health services.
4.5 The ICS will be a mandatory assignment for inmates.
5. AREA MENTAL HEALTH CENTER SERVICES: Area mental health center services will be provided for inmates with moderate symptoms who need frequent or ongoing mental health services.
5.1 The institutional mental health treatment team may request and, with the approval of a psychiatrist, initiate a transfer to an area mental health center and complete SCDC Supply M-123, "Health Summary for Classification/Assignment," if the criteria in Procedure 5.2.1 through 5.2.3, below, are present.

5.2 Certain characteristics may indicate that an inmate would be an appropriate candidate for area mental health services. These characteristics include, but are not limited to:
5.2.1 inmates who have a GAF of 45-70;
5.2.2 inmates who are prescribed psychotropic medication that can have serious side effects, or require close monitoring; and

5.2.3 inmates whose condition or circumstances may require periodic evaluation, treatment, or case management by a MHP.
5.3 Area mental health centers must be located at an institution with:
•24 hour nursing coverage;
•Monday through Friday mental health staffing; and
•availability of psychiatric consultation.
6. OUTPATIENT MENTAL HEALTH CARE: Inmates in outpatient mental health care must be able to function with limited support from mental health staff.

6.1 Upon the recommendation of the mental health treatment team, the attending psychiatrist may assign MI inmates to outpatient mental health care if they meet the criteria indicated in 6.2.1 and 6.2.2, below. The treatment team must approve the assignment.

6.2 Certain characteristics may indicate that an inmate would be an appropriate candidate for outpatient mental health services. These characteristics include inmates:

6.2.1 who do not need regular or frequent counseling services to remain stable or to ensure they are not a danger to self or others; and/or
6.2.2 who have experienced only transient symptoms or problems or who are clinically stable but need to remain on psychotropic medications.
6.3 Individual appointments will be scheduled as appropriate. For inmates receiving psychotropic medications, outpatient mental health treatment generally occurs at institutions with 24 hour nursing coverage. However, inmates can receive mental health services at most SCDC institutions. Placement must be made on a case by case basis in consultation with mental health staff to ensure inmates receive appropriate care.
7. HEALTH SUMMARY FOR CLASSIFICATION ASSIGNMENT: In order for an inmate to be routinely followed by mental health services, the inmates medical classification must reflect that s/he is mentally ill (MI-1, MI-2, MI-3, or MI-4). The treatment team will discuss changes in institutional assignments prior to

requesting that a psychiatrist change the Health Summary. The following will apply:
7.1 Exceptions may be necessary if there is a predisposing medical need that necessitates an institutional transfer.
7.2 If the institutional physician does not agree with the treatment team's recommendations, the case should be referred for a psychiatric consultation.

7.3 The primary institutional assignment will be determined by the need that requires the highest level of care. The mental health, medical, special needs, or treatment program that requires a lower level of care will be included in the "Remarks" section of the Health Summary in the AMR.
7.4 If MI is indicated, an institutional assignment generally will be designated.

7.5 The diagnosis, medication, and other relevant information may be included in the "Confidential" section of the Health Summary in the AMR.

7.6 When a change in the Health Summary occurs, a narrative note must be written in the "Chronic Clinic" section of the AMR, indicating specifically what has precipitated the change. The lead CCC at the inmates institution is responsible for monitoring this process and assigning responsibility for writing this note to the appropriate MHP.

7.7 An inmate classified as mentally ill is NOT automatically limited to specific institutions. Decisions will be made on an individual basis to place inmates at institutions where their medical and mental health needs can best be met while allowing their participation in other SCDC programs, pre-release, work, etc.

8. MENTAL HEALTH TREATMENT:
8.1 Case Management: The lead MHP will ensure that mentally ill inmates at his/her institution have an assigned MHP. MHPs will ensure that treatment/service is provided appropriately to the inmates' needs. Both routine and significant contacts will be documented in the AMR. MHPs will keep the treatment team informed of each inmates progress or lack of progress, and will request any additional support as needed. Each Lead MHP will maintain a log identifying the caseloads of the MHPs under his or her supervision, to include:

•inmate name;
•SCDC #;
•diagnosis/reason for service provision;
•GAF Score (and date);
•Treatment Team review dates; and
•Health Summary status.
8.2 Treatment Team: Treatment team meetings will be scheduled by the lead MHP on the basis of the level of care being provided at each institution. The schedule will be determined by the lead MHP with the recommendation of the treatment team. The treatment team will generally consist of the lead MHP, institutional MHPs, the HCA or designee, and the institutional physician. The treatment team note will include :

•inmate name;
•SCDC #;
•mental health classification;
•reason for staffing;
•MHP recommendation;
•treatment team decision; and
•names of team members present.

8.3 Treatment Team Minutes: Treatment team minutes will be maintained by the lead MHP or designee indicating the date of the meetings, inmates names, SCDC numbers, and the staff present. A brief summary will be documented which includes decisions made by the treatment team. A note will be entered in the AMR indicating the treatment team decision(s). The minutes will be maintained for accreditation and to assist the MHPs in accurately documenting the decisions of the meetings.

8.4 Presentation of Cases to Treatment Team: Cases will be presented at treatment team under the following conditions:

•new assessment/intake (within 14 days);
•admission to caseload (recommended or transferred MI/MR) (within 14 days);
•recommendation to discharge from MI status;
•discharge plans;
•recommendations for changes;
•recommendations for referrals (psychiatry, ICS, area mental health centers);
•initial treatment/service plan;
•discussion/updates;
•quarterly updates or standard updates on treatment/service plans;
•refusal of services;
•any significant change in GAF, diagnosis, treatment/service plan; and
•behavior management plans. (Note: At the treatment teams request, an inmate may attend the treatment team meeting to be interviewed.)

8.5 Frequency of Treatment Team Staffing: Mentally ill inmates assigned to ICS and area mental health centers will be staffed at least once quarterly. Mentally ill inmates assigned to institutions with outpatient services will be staffed at least every six (6) months. Inmates classified as MI-4 will be staffed yearly.

8.6 Treatment Plans: The MHP will develop treatment plans in accordance with clinical standards within 14 working days of the inmate's initial assessment and will present them to the treatment team. Treatment plans will be reviewed by the treatment team and updated at least quarterly for area mental health inmates and quarterly for inmates assigned to the ICS. Outpatient mental health inmates will be reviewed at least once every six (6) months. In addition, when an identified problem is resolved or an additional problem needs to be addressed, reviews and updates will be documented and presented to the treatment team. Treatment plans will be filed in the "Mental Health" section of the medical record, and a narrative note will be entered in the AMR. (R&E will document treatment planning efforts on inmates each time the inmate is seen, utilizing Health Standards Documentation Guidelines.) (3-4355)

8.7 Requirements for Mental Health Services Following Inmates on Various Medications: Each inmate who is prescribed psychotropic medication for mental illness:

•must be assigned to an institution best suited to meet his/her individual need;
•will be followed by a MHP for at least as long as the inmate is on the psychotropic medication;
•will be monitored by a psychiatrist as needed;
•will be monitored by nursing services for side effects and medication compliance; and
•will be evaluated by a psychiatrist, physician, or trained physicians assistant or nurse practitioner at least once every ~~90~~180 days prior to medication renewal. (Amended by Change 2, dated June 21, 2010).

8.8 Individual and Group Counseling: The Case Manager/Lead MHP, qualified by either formal education or training, will plan and organize a counseling program to include counseling upon inmates requests and for crisis intervention. The frequency, duration, and focus of individual and group counseling will be determined by the treatment plan. New developments, concerns, or problems, as well as progress/lack of progress, clinical observations, inmate's statements, and other relevant data, will be documented in the AMR. (4-4428, 4-4433, 4-4435)

8.9 Crisis Intervention (CI): Refer to SCDC Policy/Procedure HS-19.01, "Procedures for the Placement of Inmates in Crisis Intervention Status," for information regarding CI.

9. HABILITATION PROGRAM FOR THE DEVELOPMENTALLY DISABLED (HAB UNIT):

9.1 At the R&E Centers and upon referral from institutional physicians, mental health staff will assess and test inmates to evaluate them for the Hab Unit. (4-4305)

9.2 The designated MHP must approve all assignments to the Hab Unit.

9.3 Purpose of the Habilitation Program: The Habilitation Program (Hab Unit) is designed to provide appropriate social, vocational, and academic skills programming for offenders with mental retardation or other developmental disabilities. The target population will include any inmate committed to the SCDC who demonstrates significant impairment(s) that limits his/her ability to adjust or function in a correctional environment due to mental retardation or other developmental disabilities. The inmates condition is expected to continue indefinitely. Inmates with mental retardation are the primary target population. This program is designed to address poor academic skills, limited attention span, memory deficits, poor communication skills, impulsive behavior, and poor decision making skills. Inmates primarily targeted for the Hab Unit are often preyed upon and have difficulty functioning in a general population prison environment.

9.4 Mentally Retarded (MR)/Mentally Ill (MI) Designation: Inmates with mental illness who are also mentally retarded will be listed as Mentally Ill (MI). The inmates institutional assignment will be based on the predominating need. The Full Scale, Verbal, and Performance IQ results will be listed in the "Confidential" section of the AMR along with the mental health information.

9.5 Inmates who are mentally retarded and have no identified mental health needs will be listed as Mentally Retarded (MR) on the Health Summary. If there are no complicating medical factors, MR inmates will be listed as Habilitation Unit for the institutional assignment. However, not all MR inmates will be placed in the Habilitation Unit. Only those deemed to require this program will be placed in it. Some inmates who have the medical classification "MR" may be allowed in the general population, and will be

monitored by mental health staff as needed.

9.6 The Hab Unit will be a mandatory assignment for inmates, but participation in the treatment programs and services is voluntary.

9.7 Admission: Hab Unit appropriate inmates are normally evaluated at the R&E Center where, if applicable, admission to the program is initiated. Nevertheless, some inmates may not be recognized as appropriate during the R&E screening process. Therefore, any inmate or staff member may request that medical staff assess inmates already in the general population. The SCDC physician will then complete the Mental Health Services Referral Form (Appendix 2) and forward it to the MHP for an assessment of the inmates adaptive functioning, or the MHP may be notified by CRT. The MHP will arrange for IQ testing and other clinical evaluations as soon as possible. When the evaluation has been completed, the MHP will forward the results of both the assessment and the evaluation to the Director of Mental Health Services or designee. The Director of Mental Health Services or designee will make a decision either to accept, reject, or refer to another behavioral medicine area(s). When approval is granted in writing, the attending physician will update the medical classification indicating MR and the Hab Unit assignment. The Director of Mental Health Services or designee will notify the Division of Classification and Inmate Records staff of the approval so that the inmate can be transferred to the Hab Unit facility.

9.8 Specific criteria utilized in determining eligibility include, but may not be limited to:

•Wechsler Adult Intelligence Scale-III (WAIS-III) IQ of less than 70;
•Revised Beta Intelligence Test IQ of less than 70;
•Test of Nonverbal Intelligence (TONI) IQ of less than 70;
•Wide Range Achievement Test (WRAT) Reading and Math level below 3.5;
•Clinical interview and record review which identify deficits in adaptive functioning; and
•Brigance Diagnostic Life Skills Inventory or the Street Survival Skills Questionnaire (SSSQ) measurements demonstrating lack of adaptive skills.

9.9 Staffing: Each inmate who is classified as mentally retarded will be assigned a case manager who will see the inmate at least once per month and whose primary responsibility will be to:
•conduct relevant assessments;
•develop and review individualized habilitation plan of care;
•implement skill building groups and document and monitor attendance and progress at the group meetings in the AMR;
•provide individual counseling;
•provide crisis intervention;
•serve as a liaison between the inmate and the institution as well as other service agencies; and
•assist in discharge planning, to include attending parole hearings. (4-4434)

9.10 On Call: There will be a staff member on call to respond to crisis situations 24-hours a day, seven (7) days a week. In the Womens Services Unit (WSU), this staff member will be part of the routine on-call rotation for all of Womens Services. (3-4350)

9.11 Treatment Team: The Hab Unit treatment team will consist of the Hab Unit staff and relevant operations, medical, and educational staff. The team will meet monthly to review individualized habilitation

plans (IHPs) and the treatment issues of individual inmates.

9.12 Life Skills Component: The life skills component will consist of a detailed assessment of individual skill deficits and the development of relevant skill training programs based on these deficits. Adaptive skills, or life skills, will be assessed for each inmate admitted to the Hab Unit using the Brigance Diagnostic Life Skills Inventory. This criterion-referenced test will provide a comprehensive assessment that spans the content of life skills curricula. Skills measured will be considered important for post incarceration adaptation of adults with mental retardation and will include areas of personal management, daily living, consumer education, socialization, and community access. Relative strengths and weaknesses will be observed and individualized habilitation plans and treatment needs will be based on the results.

9.13 Individualized Habilitation Plans (IHPs): An IHP will be developed for each inmate within 21 days of admission to the Hab Unit. Each plan will include criminal history, updated classification information, entire social history, psychological evaluation, relevant medical data with information on physical limitations and work restrictions, mental health history, support services needed upon release, results of adaptive and life skill assessments, major strengths and weaknesses, and recommendations for skill building groups. Each plan will be reviewed by the treatment team and updated annually.

9.14 Life skills Training: Life skills training groups will be organized within four (4) major areas and will be set up on a quarter system with 10 to 12 sessions per group. Inmates will be assigned to groups based on measured skill deficits and projected attrition rate.

9.15 Individual Counseling: Personal issues, family related problems, and institutional adjustment problems will often be addressed in individual counseling. An emphasis will be placed on the development of individual problem solving and decision-making skills. (4-4428, 4-4435)

9.16 Discharge from the Hab Program: Refer to Paragraph 16., "Discharge/Community Release Planning for Inmates Receiving Mental Health Services."

9.17 Work Component: All inmates diagnosed as mentally retarded will be required to work as an integral part of their treatment plan. The work component will be designed to secure jobs in areas where inmates can develop and refine appropriate work behavior while gaining marketable job skills. Engaging in work-related activities in a positive environment while incarcerated will help the inmate to adjust to the institution as well as provide work experience for those who will eventually return to the community. An inmates previous work experiences, skills, vocational training, medical work evaluations (MEDCLASS), and demeanor will be considered when assigning an inmate to a job. Mentally retarded inmates may be represented by their primary caseworker at the Institutional Classification Committee (ICC) for job placement.

9.18 Special Education: Special education services, including outreach programs, will be provided through the Palmetto Unified School District. State certified special education teachers will conduct classroom curricula that are consistent with state and federal regulations. In accordance with Public Law 94-142, priority will be given to those offenders who are under 21 years of age. The overflow of those in need of educational services will be handled by mainstreaming inmates into adult literacy and functional academics.

10. SEX OFFENDER TREATMENT PROGRAM (SOTP): Specialized treatment services for sex offenders will be provided by the staff of the Sex Offender Treatment Program (SOTP). The SOTP provides educational groups, treatment groups, and relapse prevention groups to inmates sentenced under the Youthful Offender Act and straight-time inmates. While SOTP staff will monitor the mental health

status of their clients, in-patient care and/or intensive mental health care will be accessed through the referral process.

11. YOUTHFUL OFFENDER INTENSIFICATION PROGRAM: The YOIP is a free-standing program with comprehensive and exclusive services. Inpatient care and/or intensive mental health care will be accessed through the referral process. YOIP inmates with developmental delays and significant physical or communication deficits will be evaluated by the YOIP staff and referred to the appropriate program. See SCDC Policy/Procedure PS-10.09, "Youthful Offender Intensification Program (YOIP)," for additional information. (4-4305)

12. SUBSTANCE ABUSE TREATMENT: Treatment for chemical dependency will be provided by the Division of Substance Abuse Services. Those inmates who are dually diagnosed will receive services from the Division of Substance Abuse Services, but must be psychologically and medically stabilized, and documented as such, prior to any provisions of substance abuse services. The appropriateness of such referrals will be monitored. Substance Abuse Services employees will be responsible for the monitoring of the mental health status of their clients. The Division of Substance Abuse Services staff will provide substance abuse services to inmates identified as needing substance abuse residential and/or non-residential services. Referrals for substance abuse services will be in accordance with SCDC Policy/Procedure PS-10.02, "Inmate Substance Abuse Services" and determined by the Division of Substance Abuse Services. The Division of Substance Abuse Services is responsible for determining the appropriateness of referrals to these programs (4-4438, 4-4439, 4-4440, 4-4441)

13. MATERNAL SERVICES: The MHP designated as the pre-natal custodial coordinator will coordinate the custodial placement of newborns of inmates. All pregnant inmates (except for inmates assigned to the Youthful Offender Intensification Program (YOIP) will be assigned to the Camille Griffin Graham Correctional Institution for the entire pregnancy and remain at this institution until the six (6) weeks post partum physical exam has been completed.

13.1 The pre-natal custodial coordinator will inform the inmate that the inmate must identify a person(s) who will take custody of the child upon delivery (birth). The pre-natal custodial coordinator will have the inmate complete the "Newborn Child Custody Designation," (Appendix 1) which identifies the prospective custodian for the child. The "Newborn Child Custody Designation" should be completed prior to the birth of the child and will be notarized and filed in the inmate's medical record.

13.2 The pre-natal custodial coordinator will contact and verify the willingness of the prospective custodian to receive the child after delivery and take custody. The pre-natal custodial coordinator will contact the designated hospital liaison/social worker to ensure that appropriate procedures are followed. If the prospective custodian fails to show or take custody of the child, the hospital liaison/social worker will notify the South Carolina Department of Social Services (SCDSS). The pre-natal custodial coordinator will follow-up on all deliveries to determine the final custody of the child.

13.3 The pre-natal custodial coordinator will not recommend adoption or any adoption agency. If the inmate desires adoption, she will be referred to the SCDSS or the inmate may work through her family or through private legal resources to obtain adoption services. If the inmate designates or requires referral to the SCDSS, the pre-natal custodial coordinator will notify the SCDSS of the referral as soon as possible. If private adoption is pursued by the inmate, the inmate will be informed that it is the inmate's responsibility to supply the pre-natal custodial coordinator with evidence of who will take custody of the child after delivery. The pre-natal custodial coordinator will monitor inmates selecting private adoption and will ensure this information is coordinated with the liaison/social worker at the designated hospital. The pre-natal custodial coordinator will post a note in the automated record that details the option that the inmate chose and the name and phone number of the designated and verified prospective custodian. (4-4436)

14. HANDICAPPED SERVICES: Inmates with significant mobility, sensory, or communication problems identified by the institutional physician may be approved to be assigned by the Medical Director to a Handicapped unit where they can be provided needed assistance. (Refer to SCDC Policy/Procedure HS-18.15, "Levels of Care," for further details.) Inmates assigned to handicapped beds may have mental health diagnoses and/or developmental delays in addition to the handicapping condition. These additional conditions will be noted in the Health Summary along with the secondary mental health institutional assignment, and the diagnosis will be listed in the "Confidential" section of the AMR. Mental health services for these inmates will be coordinated by the mental health staff in cooperation with medical and other program services. Handicapped services will be provided concurrently with mental health and other special needs services. (4-4277, 4-4305, 4-4429, 4-4450)

15. HOSPICE SERVICES: The Hospice and Palliative Services Program will provide emotional, spiritual, and medical care to terminally ill inmates, or inmates having a life-threatening or chronic condition which is not yet terminal, using hospice, medical, mental health, and pastoral staff members, as well as inmate volunteers. An institutional MHP will be a member of the hospice interdisciplinary team. Each hospice/palliative services inmate will be assigned to a MHP who will: conduct a psychosocial assessment

using SCDC Supply M-131, "Admission Assessment - Interdisciplinary"; develop a hospice (using SCDC Supply M-132, "Interdisciplinary Care Plan - Hospice") or palliative (using SCDC Supply M-140, "Interdisciplinary Care Plan Service") services treatment plan for that inmate; and provide individual contacts with the inmate addressing issues as determined by the treatment plan. Refer to SCDC Policy/Procedure PS-10.10, "Hospice and Palliative Service Program," for further details. (4-4305)

16. REFERRAL TO MENTAL HEALTH SERVICES:

16.1 Initial Requests for Mental Health Services (referring inmates who are not currently being served by Mental Health or other treatment and/or Special Needs Program): Requests for mental health evaluation and/or services may be initiated by an inmate, inmate's family, or any staff member. The following will apply:

16.1.1 Inmates requesting services must complete a SCDC Form 19-11, "Request to Staff Member," and forward it to medical.

16.1.2 If a family member requests that an inmate be evaluated, the staff member receiving the request (verbal or written) will complete an SCDC Form 19-29A, "Incident Report," detailing the information obtained. The "Incident Report" will be forwarded to medical.

16.1.3 Any SCDC staff member may request that an inmate be evaluated by completing SCDC Supply M-122, "Referral/Action Taken Form," detailing the concern or incident precipitating the request, and forwarding it to medical.

16.2 Medical Management of Referrals: Medical staff will evaluate the referred inmate at regularly scheduled sick call prior to referring the inmate for mental health services. If a mental health referral is warranted, medical staff will complete Appendix 2, "Mental Health Services Referral," and forward it to the lead MHP. Referral can also be made to the CCC by way of the AMR. Medical's assessment will include:

- the referral source (inmate, security, physician);
- the reasons for referral, presenting problems, history of problem, mental status, etc.;
- whether the referral is a priority (to be seen within three [3] working days) or non-priority (to be seen within ten [10] working days); and
- pertinent physical information.

Medical staffs assessment of the inmate will be documented in the medical record/AMR. If it is determined that the request would be more appropriately handled by another area (e.g., operations, classification, chaplaincy), the request will be forwarded as appropriate. With the exception of emergencies, the assigned institutional mental health staff will evaluate the inmate prior to other referrals for mental health services (e.g., psychological evaluations, treatment programs) being initiated.

16.3 Referral of Inmates Already Known to be Mental Health Clients: When medical staff receive an SCDC Form 19-11, "Request to Staff Member," or SCDC Form 19-29A, "Incident Report," or SCDC Supply M-122, "Referral/Action Taken Form," regarding an inmate already designated as mentally ill or who is currently being served by the Hab Unit, who is handicapped, or who is in some other treatment program, medical staff may forward the request directly to the inmates Mental Health Case Manager, as may be clinically appropriate.

16.4 Mental Health Management of Referrals: The case manager will complete a Mental Health Services Referral (Appendix 2) whenever an inmate designated as mentally ill is transported to ICS, Habilitation Service Program, Area Mental Health, Institutional Outpatient Mental Health, and/or GPH Outpatient Evaluation. The referral will be forwarded to the designated MHP responsible for classification and movement. The designated MHP will approve the move and coordinate details of the move. Referrals for initial assessment and follow-up will be forwarded to the lead MHP or designee for assignment to mental health staff for assessment. Assessments will be completed in a time frame consistent with the type of priority status (i.e., priority within three [3] working days and non-priority within ten [10] working days), and include the following information:

•precipitating stressors or events;
•presenting problem, history of problem;
•current mental status;
•assessment of risk of harm to self and others;
•recommendation for services; and
•documentation of action taken if crisis services are necessary.
A summary of the assessment and recommendations will be documented in the AMR.16.5 Referral of Inmates upon Institutional Intake and Transfer: When an institution receives an inmate with MI, MR (but not assigned to the Hab Unit) status, the medical staff will send the lead MHP or designee Appendix 2, "Mental Health Services Referral," to notify the staff of the inmate's arrival, or notify the CCC via the AMR. Unless the following are applicable, standard nursing intake will be sufficient, and mental health assessment will not be immediately necessary. If, however, either of the following is present, mental health will assess the inmate as a priority referral as soon as possible, but no later than three (3) working days: The inmate has an active psychiatric problem (e.g., obvious behavior problems, per nursing transfer note, or a pending psychiatric appointment); the inmate is returning from CIS, GPH, or SCDMH/contract facility.

16.6 Habilitation Unit Inmates: When a Habilitation (Hab) Unit inmate arrives at the Hab Unit institution, the medical staff will refer him/her to the Hab Unit.
16.7 Sex Offender Treatment Program Inmates: SOTP inmates will be referred to the SOTP staff for assignment to a MHP. If the inmate is also MI or MR, this information must be indicated on Appendix 2 "Mental Health Services Referral," or via referral in the AMR. If the inmate is transferred to an outpatient SOTP, this information will be indicated on the referral. Health Summaries will be reviewed by the SOTP staff for accuracy, and medical records from prior mental health treatment will be requested during intake (if not previously done). See SCDC Policies/Procedures related to Sex Offender Treatment.

16.8 Mental health staff will provide 24 hour on-call consultation when needed. The following will apply:
16.8.1 Routine assessments will be addressed by institutional mental health staff the next working day.

16.8.2 In extenuating circumstances, when mental health emergencies arise after hours that cannot be handled by medical staff, the on-call MHP may be contacted by medical to provide consultation and recommendations. On-call MHPs will respond to pages within 30 minutes.

16.8.3 Medical staff will notify the MHP that an inmate has been admitted to inpatient or placed on Crisis Intervention as soon as possible during normal working hours, or the next working day if the placement occurs at night or on a weekend. (3-4350)

17. DISCHARGES FOR INMATES RECEIVING MENTAL HEALTH TREATMENT: When an inmate's function improves to the point that s/he may be discharged from the mental health program, the following will apply:

17.1 ICSDischarges: ICS inmates will generally be referred to an area mental health center upon discharge.

17.2 Area Mental Health Center: Area mental health center inmates will be assigned a level of care by the mental health treatment team.

17.3 Mental Health Services: Inmates may be recommended for discharge from all mental health services after the case has been staffed by the institutional treatment team, with concurrence from the area mental health supervisor or a mental health program manager, or upon the recommendation of a physician, preferably a psychiatrist. Generally speaking, inmates should be off medication and stable for at least three (3) months before being considered for removal from the MI list. Upon discharge from mental health services, a summary note will be entered in the AMR by the MHP to reflect the actions/recommendations of the mental health treatment team and discontinuation of any medications. The Health Summary will then be updated by a psychiatrist to reflect "No Mental Health Treatment."

17.4 Treatment Team Recommendations: The inmate's conditioning/functioning will be discussed by the treatment team and the inmate will be approved/disapproved for discharge. The treatment team may recommend referral to another treatment area such as area mental health center or outpatient mental health. If the inmate's adaptive skills deteriorate after discharge, the inmate may once again be referred to the appropriate mental health service.

17.5 Discharge Summary: Once the treatment team approves the discharge, a discharge summary will be completed by the primary caseworker, and the Health Summary (medical classification) will be updated by the physician to reflect the recommended level of mental health care, if applicable. This information will be communicated to the designated MHP. The designated MHP will contact the Division of Classification and Inmate Records to request the transfer of the inmate to an appropriate institution and program. The automated medical record and classification screens will be updated by the primary caseworker to reflect the change.

17.6 Detailed Plan for Inmates Released from SCDC: If the inmate who is discharged is nearing the end of his or her incarceration, a detailed plan must be developed, in conjunction with the discharge planner, with specific targeted dates for completion of tasks designed to aid the transition of the mentally ill inmate into community based services. The inmate, family, and other individuals or institutions must be engaged in the discharge planning process. Procedures for discharging a patient to the community must address, but not be limited to the following areas:

17.6.1 A financial platform to assist inmates in financing basic needs must be established. All disabled inmates will be assisted in applying for disability in accordance with SCDC's pre-release agreement with the Social Security Administration. It is essential that eligibility for Supplemental Security Income/Social Security Disability be established for any inmate requiring special medical equipment.

17.6.2 Shelter must be available for the patient at the time of release from incarceration. Reasonable efforts should be made to reunite the inmate with his or her family. However, alternate housing should be found when shelter with the family is not available, when the inmate does not wish to return home, or when it is not advisable or practical for the inmate to return to the family.

17.6.3 Any inmate who is in active treatment in an SCDC mental health program at the time of release from incarceration should be referred to a community provider such as a South Carolina Department of Mental Health (SCDMH) center or private provider. The appointment should be scheduled early enough to allow the individual to be seen by the community physician prior to running out of ~~the usual (2) week~~ a five (5) day supply of medication provided by SCDC. Some inmates will choose to continue treatment with private physicians and should be assisted in arranging for continued care. Other inmates (and perhaps family members) will assume responsibility for arranging care and other inmates may decline to accept offers for assistance. All efforts to arrange for care should be documented in the medical records. Inmates who do not want assistance in arranging after care must sign a SCDC Supply M-53, "Refusal of Medical Advice."

17.6.4 Some inmates will require continued hospitalization at a SCDMH hospital at the end of their sentence. Hospitalization must not be used as a substitute for discharge planning for SCDC staff and lack of housing is not a sufficient reason for referral to a SCDMH hospital. Specific procedures to be utilized in arranging hospitalization will be developed by the Division Director of Mental Health Services and will be provided to designated staff.

17.6.5 Employable inmates and those who have the potential for employment should be referred to Job Service or the local office of the South Carolina Department of Vocational Rehabilitation.

17.6.6 Any inmate who has a documented diagnosis of mental retardation and/or related disabilities will be referred to the local Disabilities and Special Needs Board prior to his/her release from incarceration.

17.6.7 Arrangements must also be made for continuing treatment of medical problems.

17.6.8 Appropriate follow-up arrangements must be made for inmates who, as a result of outstanding

criminal charges, are released to detention centers or other jurisdictions at the end of their sentences.

17.6.9 Mentally ill inmates from other states may be incarcerated in SCDC. Discharge planning for these individuals may be difficult. However, it is essential that basic needs such as shelter, transportation, and follow-up care be addressed for these inmates.

17.6.10 Discharge planners should coordinate transportation home for the inmate. Families should be encouraged to pick up inmates upon release. If there is no one available to pick up the inmate, transportation will be arranged pursuant to Agency policies on the release of inmates.

17.7 The needs of an inmate who will be released to the community are not limited to those areas addressed above. The inmate must be assisted in accessing all community resources that will maximize his/her chances for successful return to the community. A discharge summary must be written at the time of discharge from the program. The discharge summary is a detailed written record of the patient's treatment and recommendations for his/her continued care. With the inmate's written permission, a copy of the discharge summary will be sent to any treatment provider to which s/he is referred for continuing treatment.

17.8 Max-Out/Parole/Supervised Furlough/Medical Furlough Planning: (1) Mental health and special needs inmates who are maxing-out or to be paroled will be staffed by the treatment team at least three (3) months prior to the release date, if possible. A specific plan for post release services, living arrangements, and supervision will be developed. Refer to paragraphs 17.6 through 17.8, for information on community release planning for inmates receiving mental health treatment. (3-4330, 4-4442, 4-4446)

18. ASSESSMENTS FOR INMATES IN SPECIAL MANAGEMENT UNITS (SMU):

18.1 Classification Review Assessments (CRA) will be completed by the institution's mental health staff. The institution's classification manager will provide the CRA list to the lead MHP at least 30 days in advance of the review date. The lead MHP will ensure that the CRA list is completed and returned to the classification manager one (1) week before the Institutional Classification Committee (ICC) hearing. The CRA may be based on the most recent 30/90 day assessment. The CRA will include:

- the inmates name and SCDC number, date, and home institution;
- the inmates approach to the interview, mental status, identified problems areas, and behavioral observations; and
- recommendations as to whether there is a need for mental health treatment.

18.2 Mental status assessments will be performed on all inmates housed in an SMU facility within 30 days of admission and then every 90 days afterward until they are released from SMU status. (4-4256) 18.3 Inmates identified as MI/MR or handicapped and housed in a SMU, regardless of the reason, will not be denied services due to their status. These inmates will have a treatment plan developed that reflects services offered while in an SMU. These services will be provided based on the diagnoses, GAF, and the treatment/service plan. Services in addition to the 30/90 day assessments will be provided as clinically indicated and will be documented in the AMR. Limitations on services will be based on documentable

security concerns and/or limitations (e.g., inability to attend groups).

19. ADMINISTRATIVE ISSUES:

19.1 Mental Health and Special Needs Appointments: All mental health, Hab Unit, and SOTP appointments will be considered medical appointments. When possible, an inmate will be seen by the MHP in a medical area unless there is a substantiated risk in removing him/her from the secured lock-up area. It will be the responsibility of the Warden, HCA, and mental health supervisor to provide and/or arrange access for inmates in SMU who need mental health or special needs services. A location that allows for the required confidentiality and safety must be provided. The MHP will be responsible for scheduling appointments and sending or arranging for SCDC Form 19-45, "Order to Report," to be sent to the inmate.

19.2 Confidentiality and Release of Information: Release of the information contained in an inmate's health record will be the responsibility of Health Information Resources (HIR), and requests for release of information will be forwarded to HIR. Mental health, special needs, and/or SOTP staff will not release any documents from the inmate's medical record. (See SCDC Policy/Procedure HS-18.07, "Inmate Health Records," for further details.) Inmates asked to sign releases of information will be educated and advised about medical record confidentiality and limitations. Release of information will be obtained prior to any contact with other agencies or relatives of inmates. (4-4095, 4-4099, 4-4396)

19.3 Inmate requests to see their own mental health records will be forwarded to the Division Director of Mental Health Services or designee as outlined in Medical Directive 900.A-6, "Inmate Access to His/Her Own Health Records." (4-4098) 19.4 Work Schedules: Leave for lead MHPs will be approved by the Division Director of Mental Health Services or designee. Leave for all other institutional mental health staff will be approved by the MHP supervisor or designee. In the case of unexpected emergency where leave will result in a significant disruption of provision of services/coverage, the immediate supervisor will ensure that the shift and/or area is covered and that the HCA at the affected institution is informed of the arrangements made for mental health coverage. See SCDC Policy/Procedure ADM-11.36, "Dual Supervision," for additional information.

19.5 On-call Assignments: Twenty-four (24) hour on-call services will be provided for every SCDC institution. An on-call schedule will be provided by the mental health supervisor to all MHPs and to each HCA as well as to operations at the institutions. The on-call list will include the on-call beeper number and the number of the back-up MHP. On-call beeper numbers will be used exclusively by mental health staff for the purpose of providing emergency services. Every attempt should be made by on-site medical and operations staff to resolve after hour emergencies without the need for an on-site visit by the mental health staff. Notifications to mental health staff of CIS placements should be made the next working day. On call staff will respond to the page as soon as possible after the page. A return call will be made for every page. (3-4350) 19.6 Documentation: All mental health and special needs contacts will be documented in the AMR according to Health Services Documentation Standards Guidelines. Clinic notes such as assessments, individual and group therapy, and AMR 30/90 day assessments will be documented in the DAP or SOAP format. Incidental notes (e.g., missed appointments; referrals; contact with other divisions, agencies, etc.; and documentation not involving inmate contact, such as treatment team) will be completed in narrative form.

19.7 ACA Accreditation and Quality Assurance: The lead MHP or designee will assist the institutional designee in preparing mental health, special needs, and SOTP documentation needed for the Management Review Program. It is the responsibility of the Division Director of Mental Health Services to ensure that programs and care are designed in accordance with ACA standards, where appropriate and that programs are reviewed/revised annually. A system of ongoing monitoring of services will also be in place. (4-4430)
19.8 Voluntary Treatment: Assignment of an inmate by staff to the institutional location of the ICS or Hab Unit, or to an appropriate area of outpatient mental health in an institution will be mandatory. The inmate's participation in any treatment programs and services will be voluntary.

20. DEFINITIONS:

Axis I and II Diagnoses refer to diagnoses on two (2) of the five (5) axes in the multiaxial mental health system that evaluates the individual along several variables. Axis I and Axis II comprise the entire classification of mental disorder, 17 major classifications, and more than 300 specific disorders. In many instances the individual has a disorder on both axes. Axis I consists of clinical disorders and other conditions that may be a focus of clinical attention. Axis II consists of personality disorders and mental retardation. These diagnoses are referenced in the DSM-IV-TR published by the American Psychiatric Association.

Behavior Management Plan refers to an individualized treatment plan for mentally ill inmates that is part of and consistent with the master mental health treatment plan. (3-4355)

Case Management refers to the coordination, management, and provision of mental health services for inmates identified as Mentally Ill or Mentally Retarded, according to the mental health status or institutional assignment indicated in their Health Summaries.

Case Manager refers to the lead mental health professional responsible for providing Case Management services. The case manager will be qualified by either formal education or training. (4-4433)

Crisis Intervention Status (CIS) refers to the removal and transfer of an inmate from the general population to a Special Management Unit (SMU) bed, infirmary bed, or other secure bed designated by operations and/or mental health and medical staff for the purpose of providing mental health and health care professionals the opportunity to evaluate the need for mental health treatment and provide a safe environment for an inmate who may be depressed, emotionally upset, or exhibiting agitated behavior. Inmates placed in CIS may remain on this status for a maximum of seven (7) days. This is to allow the inmate to be removed from immediate stressors, be protected from self-harm or from being a danger to others, and be provided a period of observation and assessment.

Global Assessment Functioning (GAF) Scale refers to a scale used for reporting the clinician's judgment of the inmate's overall level of functioning, as defined by the DSM- IV-TR criteria on Axis V.

Mental Health Professional (MHP) refers globally to Division of Mental Health Services clinical staff responsible for provision of Mental Health Services. The Division Director is an individual at the

Headquarters level who, by training and experience, is qualified to oversee the delivery of mental health and related services statewide. The Lead MHP refers to the individual at the institutional level who is designated to supervise other MHPs assigned to that institution. The Lead MHP is an individual with at least a Masters degree in an appropriate mental health discipline and who by training and experience is qualified to render services and direct others in counseling, human services, and other related professional activities. All MHPs possess a minimum of a Bachelors degree in the social or behavioral sciences and provide clinical services to inmates only to the extent that they are qualified to do so by training, experience, or licensure. Mental Health Professionals (MHPs) are also known by their State Government Classification (Human Service Specialist/Coordinator HSS or HSC) or by their SCDC Classification (Clinical Correctional Counselor CCC). (3-4336)

Mental Health Services refer to services provided to inmates by mental health professionals.

Mentally Ill refers to those inmates identified as MI on the SCDC Health Summary indicating that they have met the criteria for admission to mental health programs.

Treatment Team refers to a team of medical and mental health professionals who meet to discuss, monitor, and/or plan for the mental health treatment of inmates. (3-4369)

Jon E. Ozmint, Director

ORIGINAL SIGNED COPY MAINTAINED IN THE DIVISION OF POLICY DEVELOPMENT.

Appendix 1

# Newborn Child Custody Designation

Inmate Name:_____ Inmate Number: _____

I, _____, understand that I am responsible for selecting someone to take care of my unborn child and appoint the individual(s) shown below to take physical custody of my child until otherwise stated. I understand that the person I select is responsible for paying the child's hospital bills.

I agree to inform the appointed caretaker of the child that she/he will be responsible for the child's hospital bills. I agree to share this information with the caretaker as soon as possible and prior to the child's birth.

According to state regulations, relatives (maternal or paternal grandparents, aunts, uncles, first cousins, and adult siblings) may apply and be eligible to receive Aid to Families with Dependent Children (AFDC) for my child.

## Information on Individual(s) Appointed to Take Physical Custody of My Child

Name of Appointed Caretaker:_____

Address:_____

Relationship:_____

Phone Number(s):_____

Expected Birth Delivery Date: _____

Inmate's Signature:_____ Date:_____

_____ _____

Witness Signature Witness Signature

cc: SCDC Health Services
Delivering Facility (Hospital)

Note: Newborn child may be picked up 36-48 hours after birth. The appointed caretaker listed above should contact the hospital to make sure the baby is ready to be picked up. Call Palmetto Baptist Hospital at 803-434-6455.

Appendix 2

South Carolina Department of Corrections
Mental Health Services Division

Mental Health Services Referral

Referring Staff:_____ Date of Referral:_____

Referring Institution:_____

INMATE INFORMATION:

Name:_____ SCDC #:_____

Institution:_____ Age:_____ Sex: M_____ F_____

Current Offenses:_____

Sentence:_____ Max-Out Date:_____

GAMA/Beta Score:_____ WRAT Score: _____ WAIS:_____

REFERRAL TO:

Area [X] Referral Program &Eligibility Criteria

[ ] Intermediate Care Services (ICS): Inmates with chronic, debilitating mental illnesses that are not serious enough to require hospitalization but require intensive treatment and monitoring, those with GAF scores in the 31-50 range for extended periods of time. Inmates admitted to this program normally have chronic or serious disturbances in the ability to function normally on a daily basis, multiple hospitalizations, and a need for a highly structured environment.

[ ] Habilitation Services Program (HSP): Inmates with a diagnosis reflecting the presence of Mental Retardation or serious cognitive disorders. These inmates should have documented testing in the intellectual range of mental retardation. Inmates admitted to this program must demonstrate significant limitations in at least three major life areas: self-care, self-direction, learning, capacity for independent living, economic self-sufficiency, hearing/speech/language (excluding blindness), and receptive/expressive language.

[ ] Area Mental Health (AMH): Inmates who have mild to moderate symptoms of mental illness, a GAF of 51 or above, and who require frequent or ongoing access to psychiatric consultation.

[ ] Institutional Outpatient Mental Health Program: Inmates with a mental illness designation assessed as capable of living independently and functioning normally on a daily basis among the general population. These inmates are treatment and/or medication compliant.

[ ] GPG - Outpatient Evaluation: Inmates in need of psychiatric consult/evaluation for medications and diagnosis.

REASON FOR REFERRAL: _____

_____

_____

_____

MENTAL HEALTH HISTORY: _____

_____

_____

_____

MEDICAL HISTORY AND CONDITION: _____

_____

_____

_____

DIAGNOSES:

Axis I: _____

_____

Axis II: _____

_____

Axis III: _____

_____

GAF: _____

Medications: _____

_____

MENTAL HEALTH RECOMMENDATIONS:

_____Approved _____Disapproved by: _____

_____Approved _____Disapproved by: _____

_____Approved _____Disapproved by: _____

REASON FOR DISAPPROVAL: _____

_____

Date: _____

Distribution: Mental Health Services (MHS), Referred MHS Program, Medical Record